No. 87-5096

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

QUINCY WEST,

Petitioner,

VS.

SAMUEL ATKINS,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE* AND BRIEF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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BRIEF OF AMICUS CURIAE

The American Public Health Association ("APHA") moves pursuant to Rule 36.3 of the Rules of the Supreme Court of the United States for leave to file a brief amicus curiae in support of petitioner. The written consent of petitioner has been filed with the Court. Although respondent has advised APHA that he does not oppose

the filing of the brief, he has not provided written consent.

APHA is a national non-governmental organization established in 1872 for the purpose of improving the quality of public health. Together with its affiliates, APHA is the largest public health association in the world, with a combined multidisciplinary membership of approximately 50,000 health care professionals and consumers. APHA has appeared before this Court on numerous occasions as amicus curiae in cases with serious implications for the public health. See, e.g., Roe v. Wade, 410 U.S. 113 (1973); Hardwick v. Bowers, ___ U.S. ___, 106 S.Ct. 2841 (1986).

APHA has a special interest in assuring adequate health care for underserved segments of society. In the early 1970's, when the concept of furnishing appropriately comprehensive health services to inmates was controversial, APHA appointed a task force to devise standards for health care in prisons and jails. The resulting publication, Standards for Health Care in Correctional Institutions, the first document of its kind, appeared in print in 1976.[1]

Because of its broad knowledge of the problems of prison medical care, APHA believes it will present to the Court a valuable perspective on the issues that this case presents, including the role of health staff in correctional facilities and the application in injunctive suits of the "deliberate indifference" standard of Estelle v. Gamble, 429 U.S. 97 (1976).

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[1] A new, revised edition of these standards is lodged with the Clerk of Court. Standards for Health Services in Correctional Institutions (2d ed. 1986).

Consistent with its purpose of advancing the public health and in the hope of decreasing the human suffering caused by unconstitutional care, APHA requests leave to file this brief.

Respectfully submitted,

/S/
William J. Rold

Dated: December 10, 1987
New York, New York

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INTEREST OF AMICUS CURIAE
AMERICAN PUBLIC HEALTH ASSOCIATION

The interests of the American Public Health Association (APHA) are set forth in its motion for leave to file this brief as amicus curiae, which is bound herewith pursuant to Rule 36.3 of the Rules of this Court. APHA has lodged with the Clerk of Court a copy of its recent Standards for

Health Services in Correctional Institutions.[1]

SUMMARY OF ARGUMENT

The court below erred in holding that prison medical practitioners do not act under color of state law. The court incorrectly assumed that, "[w]here the professional is acting within the bounds of professional discretion and obligation, his independence from administrative direction is assured." West v. Atkins, 815 F.2d 993, 995 (4th Cir. 1987). In reality, the prison's nature as a closed "total institution" constrains the medical discretion of even the most independent physician in numerous and inescapable ways; and many of the customary

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[1] See Standards for Health Services in Correctional Institutions (2d ed. 1986) [hereinafter "APHA Standards"].

safeguards, such as accreditation and peer review, that reinforce adherence to medical standards are absent.

The court also falsely assumed that prison doctors lack "custodial or supervisory" responsibility, id.; in fact, such responsibility pervades prison medical practice. Thus, this case is not governed by Polk County v. Dodson, 454 U.S. 312 (1981), in which the Court held that a public defender representing a client did not act under color of state law because of the adversary nature of the criminal process and the defender's nearly unqualified obligation to act in her client's interest. By contrast, the prison medical practitioner is engaged in carrying out the state's purposes as much as the prisoner's.

Federal court litigation has been essential to the development of minimally

decent medical care in prisons and jails, and the continued availability of the federal forum is essential to preserving and extending this progress. Such litigation has not improperly invaded medical discretion or professional judgment, which is protected by the established legal standard requiring that prisoners prove "deliberate indifference" in order to state a constitutional claim. Estelle v. Gamble, 429 U.S. 97 (1976). Medical malpractice is not litigable under 42 U.S.C. § 1983; the federal courts review only claims of outright denial of care, extreme or abusive behavior, failure to exercise medical judgment, or failure to act on medical orders once they have been written. In injunctive cases, litigation has enhanced the autonomy of medical personnel by assuring the resources necessary for exercise of professional judgment.

Adoption of a "color of law" rule that broadly excludes prison medical staff as parties in civil rights cases would remove from federal scrutiny the activities of those persons who, by training and responsibility, are in the best position to assure that constitutionally adequate care is provided. Moreover, their exclusion would result in medical care injunctions running only against wardens and other lay personnel, who cannot realistically supervise medical staff, and whose attempts to do so could jeopardize their professional autonomy.

Health care practitioners should be deemed to act under color of state law when they treat inmates more than occasionally in a setting that is demonstrably correctional or under circumstances that substantially d.stinguish the prisoner-patient from other patients

served. The employment status of the practitioner should not be determinative; contractual and part-time physicians as well as full-time prison employees may be subject to the constraints of prison practice. The proposed standard lends itself to the "necessarily fact-bound inquiry" prescribed by this Court, Lugar v. Edmondson Oil Co., 457 U.S. 922, 939 (1982), and acknowledges that "differences in circumstances beget differences in law...." Jackson v. Metropolitan Edison Co., 419 U.S. 345, 358 (1974).

ARGUMENT

I. PRISONS AND JAILS, AMONG THE MOST HIGHLY STRUCTURED OF BUREAUCRACIES, SO INFLUENCE MEDICAL AUTONOMY THAT PROFESSIONAL INDEPENDENCE WITHIN THE MEANING OF POLK COUNTY v. DODSON **CAN BE NEITHER ASSUMED NOR ASSURED.**

The court below adopted a state action test that assumes that prison medical staff exercise the same professional

independence as their free world counterparts. Its sweeping statement that, "[w]here the professional is acting within the bounds of professional discretion and obligation, his independence from administrative direction is assured," West v. Atkins, 815 F.2d at 995, ignores both the realities of the correctional setting and the substantial body of literature showing that medical professionals in institutions, and in prisons particularly, have limited independence and often become entangled in non-health concerns.

It is APHA's experience that the care delivered by institutional physicians is greatly influenced by the organization in which they find themselves.[2]

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[2] Physicians' training has been repeatedly shown to affect their performance less than does the site of their practice. Palmer & Reilly, "Individual and Institutional Variables Which May Serve as Indicators of Quality of Medical Care," 17 Medical Care 693, 699 (1979). Indeed,

Bureaucracies "subjugat[e]... professional standards to administrative consideration in the decision-making process,"[3] foster-

(footnote cont'd)

very different treatment is provided by the same physicians when they practice in municipal rather than voluntary hospitals. See Mates & Sidel, "Quality Assessment by Process and Outcome Methods: Evaluation of Emergency Room Care of Asthmatic Adults," 71 Am. J. Public Health 687-690 (1981); Rubenstein, et al., "Quality-of-Care Assessment by Process and Outcome Scoring: Use of Weighted Algorithmic Assessment Criteria for Evaluation of Emergency Room Care of Women with Symptoms of Urinary Tract Infection," 86 Annals Int. Med. 617 (1977).

[3] Lichtenstein, "A Classification of Prison Health Systems based on Their Bureaucratic Attributes," 3 J. of Prison & Jail Health 40, 43 (1983), quoting Blau, "The Hierarchy of Authority in Organizations," in Heydebrand (ed.), Comparative Organizations: The Results of Empirical Research, Englewood Cliffs, N.J.: Prentice-Hall (1973). Accord, Engel, "The Effect of Bureaucracy on the Professional Autonomy of the Physician," 10 J. of Health & Soc. Behavior 30 (1969) (literature suggests that bureaucracy restricts the professional's freedom, makes him dependent on the organization, and "inhibits the application of his knowledge and skills"); Hall, "Professionalization and Bureaucratization," 33 Am. Soc. Rev. 92, 103 (1968) (inverse relationship

ing in professionals a "lack [of] autonomy which is vital for successful performance."[4]

This process is particularly powerful in "total institutions" such as prisons and jails that, by design and in practice, are removed from the community and operated to emphasize their separation from all aspects of the outside world,[5] including community norms of delivering health care. The strong institutional and historical factors peculiar to prisons

(footnote cont'd)

between professionalism and bureaucratization).

[4] Engel, supra n.3, at 30.

[5] Twaddle, "Utilization of Medical Services by a Captive Population: An Analysis of Sick Call in a State Prison," 17 J. of Health & Soc. Beh. 236, 237 (1976); see also Goffman, Asylums at 4 (1961); Ingraham v. Wright, 430 U.S. 651, 669-70 (1977).

affect the practice of medicine and constrain the choices made by health practitioners to such an extent that it cannot be assumed that a physician practicing in this setting can meet community expectations of professional independence.

A. Administrative and Security Imperatives Affect the Exercise of Medical Judgment in a Prison.

Prisons and jails are inherently coercive institutions that for security reasons must exercise nearly total control over their residents' lives and the activities within their confines. Prison health care professionals work in a "medically alien setting"[6] to which their formal training provides no orientation. The experience changes the way medical staff exercise professional judgment.

In an institution, "[t]he general schedules that strictly regulate work, exercise, and diet necessarily collide with individual medical orders for treatment."[7] No prison physician will be unaffected by the burdens posed on the administration of the prison or jail with each medical order that requires deviation from the standard institutional regimen. The practitioner will necessarily weigh a patient's medical need for special clothing, a special diet, an extra shower, a

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[6] Wishart & Dubler, Health Care in Prisons, Jails and Detention Centers: Some Legal and Ethical Dilemmas, Curriculum Materials Developed under a Grant from the National Science Foundation at 16 (1983). A copy of these materials is lodged with the Clerk of Court. See also Brecher & Della Penna, Health Care in Correctional Institutions at 69 (Department of Justice, Law Enforcement Assistance

(footnote cont'd)

Administration 1975).

[7] Neisser, "Is There a Doctor in the Joint? The Search for Constitutional Standards for Prison Health Care," 83 Va. L. Rev. 921, 944 (1977).

permit for a cane, or more frequent access to exercise equipment against the administrative difficulty of deviating from the normal rules and the effect granting such an exception may have on other patients who might seek similar treatment or the institution's willingness to accede to such exceptions in the future.

Correctional institutions impose unusual constraints on the delivery of medical services. Prescribing drugs poses unique problems in corrections because many medications are valuable in the inmate economy.[8] As a result, physicians

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[8] See National Commission on Correctional Health Care, Standards for Health Services in Jails (1987) [hereinafter "NCCHC Standards J-__"] and Standards for Health Services in Prisons (1987) [hereinafter "NCCHC Standards P-__"], at J-22 and P-21. Copies of these standards are lodged with the Clerk of Court. The APHA Standards advise keeping use of controlled medications to a "minimum." APHA Standards, supra n.1, at Part 9; see also Part 5, Standard A.

who prescribe medications in prison by the same standards used for civilian patients may soon be in conflict with the prison administration,[9] leading some doctors to see themselves as "guardians of medication."[10]

Conversely, in some prisons and jails, drugs have been prescribed for institutional convenience rather than medical reasons. They have been used as substitutes for physical restraint,[11] as

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[9] Rundle, "Institution vs. Ethics: The Dilemma of a Prison Doctor," The Humanist 26, 27 (May-June 1972).

[10] Comment, "Inadequate Medical Treatment of State Prisoners: Cruel and Unusual Punishment?" 27 A.U.L. Rev. 92, 122 n.154 (1977), citing Rundle, "Medical Uncare for Prisoners," 1 Prisoners' Rights Newsletter 53, 54 (1971).

[11] Forer, "Medical Services in Prisons: Rights and Remedies," 68 A.B.A. Journal 563 (May 1982).

"pacifiers" in a tense and understaffed environment,[12] and even as punishment for violation of prison rules,[13] despite professional standards condemning such practices.[14]

More generally, inmates cannot self-treat such minor ailments as headaches, upset stomachs, or colds; nor may they just stay in bed when they feel ill. Such common items as aspirin, dental floss, antacids, and band-aids typically must be obtained from the prison's medical staff.

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12 Brazier, "Prison Doctors and Their Involuntary Patients," 1982 Pub. L. 282, 296-7 (1982).

13 See, e.g., Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973) (emetic drug); Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973) (paralytic drug); see also Note, "Aversion Therapy: Punishment As Treatment and Treatment as Cruel and Unusual Punishment," 49 So. Cal. L. Rev. 880 (1976).

14 NCCHC Standards, supra, n.8, J-30.d.viii and P-29.e.viii.

Thus, prisoners must seek medical assistance even if all they need is an over-the-counter remedy or a day in bed.[15]

Such prison rules, adopted for non-medical administrative reasons, greatly enlarge the demands on medical staff, fostering a tendency to characterize patients as exaggerators or malingerers.[16] For the prisoner, the normal doctor-patient association becomes a "continuing adversary relationship with those who con-

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15 See Todaro v. Ward, 431 F.Supp. 1129, 1133 (S.D.N.Y.), aff'd, 565 F.2d 48 (2d Cir. 1977).

16 Nathan, "Guest Editorial," 5 J. of Prison & Jail Health 3, 7-9 (1985). Mr. Nathan, who has served as a special master for federal district judges in Ohio, Georgia, Texas, and New Mexico, notes that the danger of minimizing the complaints of prisoner-patients is very real: "The death records maintained in prisons throughout this country provide eloquent, if mute, evidence of malingerers whose fabricated complaints proved to be fatal." Id. at 9.

trol his everyday needs."[17]

The institutional environment produces continual pressure to tailor the quality and quantity of medical treatment to demands of institutional security, productivity, discipline, and administrative convenience.[18] Even health professionals whose contact with the correctional system is limited are subject to pervasive influence. The authors of a recent correctional health journal article recommend that prisons write a "briefing sheet" for consultants that details "which procedures or medicines can and cannot be

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17 Twaddle, supra n.5, at 245. The peculiarities of the doctor-patient relationship in corrections and concern over past abuses has resulted in federal restrictions on using prisoners as subjects in behavioral and biomedical research. See 21 C.F.R. §§ 50.40-.48 (1987); 28 C.F.R. §§ 512.10-.22 (1987); 45 C.F.R. §§ 46.301-.306 (1985).

18 Nathan, supra n.16, at 11.

done or given at the institution," as well as "other rules and procedures peculiar to the institution."[19] They also offer consultants the following specific advice:

- Keep a therapeutic regimen as simple as possible.
- Avoid prescribing "exotic" medication or "non-essential" diets.
- Specify follow-up care that is within the capability of the institutional staff.
- Do not reveal future medical appointment dates to the patient.
- Recognize the "enormous amount of time and resources" involved in movement of a prisoner when scheduling return visits.
- Understand that security must be considered "an integral part of any consultative effort."
- Remember that "a sign of an escaper can be a request for a repeat visit to a consultant."
- Do not "berate[] prior care from the institution" in front of the patient.
- Be "certain and positive" lest uncertainty lead to litigation.[20]

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19 Lessenger & Bader, "Medical Consultation for Correctional Institutions," 4 J. of Prison & Jail Health 96, 104 (1984).

20 Id. at 99, 104-5.

Such institutional influence means that health staff will be under constant pressure not to exercise the discretionary functions nominally delegated to them. Sometimes, correctional influence is overt;[21] at other times, it is more subtle, fostering a "less obvious and perhaps subconscious deference" by health staff.[22] In all cases, it is present. Such considerations impinge upon the professional judgment of the health care employee in a way not encountered in the free community.

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21 "The risk of retaliation for the medical professional who dares to intrude on the turf of the deputy warden for operations is very real...." Nathan, supra n.16, at 10. Brecher and Della Penna, supra n.6, at 69, warn that a medical director "should avoid such a conflict at almost any cost."

22 Neisser, supra n.7, at 960.

B. Medical Staff Are Entangled in Non-medical Custodial and Supervisory Functions.

The Fourth Circuit, by characterizing the services of prison medical staff and consultants as wholly separate from custodial and supervisory functions, West v. Atkins, 815 F.2d at 995, citing Polk County v. Dodson, 454 U.S. at 320, ignored the realities of prison management. Commonly, health care employees are inextricably entangled in activities concerning the daily operation of the institution in a manner not expected of them in the free world. The prison or jail may depend upon health staff to certify the adequacy of food services, or the sanitation, waste disposal and hygiene systems. Their recommendations affect institutional, job, housing, and programmatic assignments,[23] and in some cases

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23 APHA Standards, supra n.1, Part 7,

will substitute for an adequate classification system.[24]

Health staff also assist the institution in ways that are directly adverse or

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Standard C.3; NCCHC Standards, supra n.8, J-08 and P-08; see also Neisser, supra n.7, at 958-9. Contrary to rules of patient confidentiality in the free community, the sharing of patient information in corrections may be expected or required. Wishart & Dubler, supra n.6, at 17; American Correctional Association, Standards for Adult Correctional Institutions (2d ed. 1981) [hereinafter "ACA Prison Standards"], Standard 2-4319, and Standards for Adult Local Detention Facilities (2d ed. 1981) [hereinafter "ACA Jail Standards"], Standard 2-5291. For an account of a physician fired for refusing to turn over a confidential psychiatric file of a patient under his care, see Rundle, supra n.9, at 26.

[24] Nathan, supra n.16, at 7. In North Carolina, health staff are directed to indicate assignment limitations for inmates so that the warden can place them in an appropriate work assignment. State of North Carolina, Division of Prisons, Health Care Procedure Manual (May 1980) [hereinafter "N.C. Prison Health Manual"], ¶ 219.2.

coercive toward their patients, such as conducting body cavity searches or other procedures to gather forensic evidence for disciplinary proceedings,[25] documenting the consequences of use of force by staff,[26] and authorizing placement or retention of inmates in solitary confinement[27] or in physical restraints.[28]

[25] United States v. Caldwell, 750 F.2d 341, 344-5 (5th Cir. 1984), cert. denied, 471 U.S. 1007 (1985); NCCHC Standards, supra, n.8, J-11 and P-11; Wishart & Dubler, supra n.6, at 102; N.C. Prison Health Manual, ¶ 704.2. The APHA Standards, supra n.1, Part 13, Standard C at 112-3, condemn this practice.

[26] See City of New York, Department of Correction, Directive 5002R (September 16, 1987) at 3, 21 (examinations after use of force "do more than provide any medical attention that is required... [they are] essential to disproving unfounded force allegations..."; APHA Standards, supra, n.1, Part 13, Standard C, condemn such use of medical staff.

[27] NCCHC Standards, supra, n.8, P-50, J-60, P-60. Such monitoring may include an assessment of the effects of deprivation of bedding or the imposition of a diet of "short rations." See APHA Standards, supra, n.1, Part 8, Standard E.2 (bed-

Indeed, health staff may be asked to participate in the administration of the penalty of death or to render an opinion as to the competency of a prisoner for execution.[29]

This involvement of medical staff in custodial and disciplinary functions, although condemned by national standards,[30] is widespead in the experi-

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ding); N.Y. Correc. Law § 137.6(c) (McKinney Supp. 1987) (diets). The New York statute requires health staff to monitor inmates receiving a restricted diet for disciplinary reasons and to make recommendations about its continuation.

[28] APHA Standards, supra, n.1, Part 3 at 27-8 and Part 5, Standard C; NCCHC Standards J-60 and P-60. (The APHA Standards ban the use of disciplinary restraints.)

[29] APHA Standards, supra, n.1, Part 13, Standard D, condemn such involvement.

[30] Id., Part 13, Standard C.

ence of APHA. Indeed, it is sometimes required by statute or regulation.[31] The effect is destructive of the professional relationship between provider and patient and engenders widespead distrust.

> No individual, however skilled an compassionate a doctor, can maintain a normal doctor-patient relationship with a man whom the next day he may acquiesce in subjecting to solitary confinement.[32]

C. Scarcity of Resources Impinges on the Professional Judgments of Practitioners in Corrections to an Extent Absent in the Free World.

Prison medical care is constrained by severe limitations of resources, both medical and correctional,[33] that

[31] See N.Y. Correc. Law § 137.6(c) (McKinney Supp. 1987); 28 C.F.R. § 552.11(c) (1987); see also n.27, supra.

[32] Brazier, supra n.12, at 285.

[33] See, generally, Comptroller General, Report to the Congress: A Federal Strategy Is Needed to Help Improve Medical and Dental Care in Prisons and Jails (Dec. 22, 1978).

inevitably shape the way medical judgments are made. To cope with high patient demand, limited resources, and the difficulty of operating in a tightly controlled environment, medical units often adopt "administratively convenient measures that deny patients access to individual medical judgments."[34] In Todaro v. Ward, 431 F. Supp. at 1143-46, for example, in a system found to be unconstitutional, overworked nurses merely collected the names of patients requesting sick call and decided later, on the basis of little or no actual information about the patients' medical complaints, which few would see the doctor.

There are many other ways in which

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[34] Neisser, supra n.7, at 959.

the exercise of medical judgment has been impaired, constrained, or rendered nominal by such non-medical considerations. Medical personnel respond to unmanageable waiting lists by categorically omitting patients seen recently, those repeating the same complaint, or those with a specified group of symptoms.[35] Alternatively, all patients are given the same palliative treatment, such as pain-killing medication, without individual diagnoses.[36] In some cases, medical services degenerate to a "care-on-demand" system in which inadequate medical resources are devoted primarily to those who complain the loudest or can best manipulate the system.[37]

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[35] See id. at 968.

[36] Estelle v. Gamble, 429 U.S. at 110 (Stevens, J., dissenting); see also Neisser, supra n.7, at 959.

[37] Conte, "Dental Treatment for Incar-

Physicians delay trips to outside specialists because of shortages in escort staff or vehicles. Needed surgery is postponed in all but life-threatening cases as patients compete for limited secure bed space or await the availability of guards.[38] Admissions to the prison infirmary are curtailed when the overcrowded prison houses healthy inmates there.[39] There is pressure to adjust the normal frequency of medication dispensing to conform to limited pharmacy hours, staff shift changes, or other prison activities.[40] Inmates needing supervised post-operative physical therapy are told simply to exercise in their cells, and those for whom root canal therapy would save natural teeth are offered only extraction.

(footnote cont'd)

cerated Individuals: For Whom? How Much?" 3 J. of Prison & Jail Health 25, 26 (1983); Dean v. Coughlin, 623 F. Supp. 392, 396 (S.D.N.Y. 1985); see Winner, "An Introduction to the Constitutional Law of Prison Medical Care," 1 J. of Prison Health, 67, 70-1 (1981) (system that fails to distinguish between patients needing prompt care and those who can wait is inadequate).

38 See Neisser, supra n.7, at 960.

39 Anderson v. Redman, 429 F. Supp. 1105, 1120-21 (D. Del. 1977); cf. Williams v. Edwards, 547 F.2d 1206, 1217 (5th Cir. 1977) (whirlpool bath for physiotherapy used by kitchen to keep fish fresh).

D. The Safeguards that Reinforce Adherence to Medical Standards of Judgment in the Community Are Weakest in the Correctional Setting.

In the larger society, there are safeguards within the medical community that reinforce appropriate norms of sound practice, but they tend to be absent or weak in corrections, rendering prison medical practitioners particularly suscep-

40 See Neisser, supra n.7, at 960.

tible to inappropriate influence on the exercise of medical judgment.

One important safeguard of standards in medicine is the continuing association with a variety of fellow practitioners through referrals, work in civilian hospitals, and membership in professional associations. This collegiality is often absent in corrections because, historically, prison health care has been isolated from the larger community.[41]

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[41] Recognition that isolation calls for outside scrutiny of prisons and their health care systems is reflected in such early statutes as the English Coroner's Acts of 1887 and 1926, requiring investigation by inquest of "all sudden, violent, or unnatural deaths, and the deaths of people in prison" whether "natural or not." Shapiro, "Forensic Medicine: Legal Responses to Medical Developments," 22 N.Y.L.S.L. Rev. 905, 908 (1977), citing Thurston, "The Coroner's Limitations," 30 Med.-Legal J. 110, 111 (1962). As of 1986, at least twenty-six states had statutes requiring or authorizing autopsies for prison deaths. Note, "Experimentation on Prisoners' Remains," 24 Am. Crim. L. Rev. 165, 176 n.58 (1986).

Until recently, most professionals have ignored this area of health care,[42] in large part because of the low salaries and social stigma associated with prisons. In addition, many institutions are located in remote rural places, far from medical libraries or tertiary care centers.

Not surprisingly, prisons have experienced enormous difficulties in recruiting and retaining qualified medical personnel.[43] Many physicians in prison health programs have been unlicensed[44] or

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[42] Lindenauer & Harness, "Care as Part of the Cure: A Historical Overview of Correctional Health Care," 1 J. of Prison Health 56 (1981).

[43] Neisser, supra n.7, at 937; see also Brecher & Della Penna, supra n.6, at 17.

[44] The Comptroller General's Report in 1978, supra n.33, at 7, 18, and 21, found reliance upon unlicensed doctors in one-fourth of the institutions studied. Some of the physicians could hardly speak English -- a problem that persists. See Wellman v. Faulkner, 715 F.2d 269, 272 (7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984).

those who, for a variety of reasons, have been unable to secure employment elsewhere.[45] Although non-binding national standards now require licensure,[46] statutes that allow institutional practice by physicians who would not be permitted to work in the free world remain on the books in several states.[47]

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[45] Wishart & Dubler, supra n.6, at 36; Neisser, supra n.7, at 937.

[46] NCCHC Standards, supra n.8, J-15 and P-15; APHA Standards, supra n.1, Part 12 at 106; ACA Prison Standards, supra n.23, Standards 2-4283, 2-4284, 2-4295; ACA Jail Standards, supra n.23, Standards 2-5270, 2-5277; American Medical Association, Standards for Health Services in Jails, Standard 117 (1981).

[47] See Ala. Code § 34-24-75(c) (1985); Colo. Rev. Stat. § 17-1-101 (1986); Ga. Code Ann. § 43-34-33 (1984); Miss. Code Ann. § 73-25-23 (Supp. 1987); Okla. Stat. Ann. tit. 59, § 489.1 (West Supp. 1987). The Georgia statute explicitly provides that the granting of an institutional license "shall not be prima-facie evidence that the holder thereof meets the minimum basic requirements for examination by the board or for the issuance of a permanent license to practice medicine."

Most prison medical care delivery systems are not subject to the standard-setting mechanism of accreditation. In the free community, significant incentives for accreditation exist that are absent in corrections.[48] Indeed, most prison systems have downgraded their hospitals to infirmaries rather than meet accreditation standards.[49] Today, the vast majority of

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[48] Accredited hospitals are deemed to be in compliance with a number of requirements for participation in the Medicare program, 42 U.S.C. § 1395bb (1983 and Supp. 1987), and may, through accreditation, be eligible for intern and resident training and lower liability insurance premiums. Dornette, "The Legal Impact of Voluntary Standards in Civil Actions Against the Health Care Provider," 22 N.Y.L.S.L. Rev. 925, 927-8 (1977).

[49] Comptroller General's Report, supra n.33, at 7.

prisons and jails in the United States remain unaccredited.[50]

Meaningful peer review, a key factor in maintaining professional standards, is not available in most prisons and jails. PSRO's (Professional Standards Review Organizations) that assume standard-setting and review responsibility over both practitioners and hospitals[51] are

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[50] Of the more than four thousand prisons and jails in the United States, Department of Justice, Report to the Nation on Crime and Justice: The Data, at 78-9 (1983), only 258 were accredited as of October 1986. National Commission on Correctional Health Care, "Report of the Accreditation Committee," Attachment A (May 2, 1987).

[51] PSRO's are required under federal law for monitoring medical services for which payment is made under the Social Security Act. 42 U.S.C. § 1320c, et seq. (1983 and Supp. 1987). Medicaid, the primary federal assistance for the health care needs of America's non-elderly indigent, is unavailable to prisoners, 42 U.S.C. §1396d (Supp. 1987).

virtually unknown in corrections.

Additional mechanisms that might be thought to help reinforce professional standards in the prison setting are, realistically, of marginal impact. The efficacy of professional grievance and disciplinary committees has been seriously questioned even in civilian life,[52] and there is slight cause to believe that they respond effectively (or even seriously) to prisoner complaints.[53] Similarly, mal-practice actions[54] are widely recognized

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[52] Derbyshire, "Medical Ethics and Discipline," 228 J.A.M.A. 59, 61 (1974), cited in Grad, "Medical Malpractice and the Crisis of Insurance Availability: The Waning Options," 36 Case West. L. Rev. 1058, 1065-6 (1986); Brook, "The Relationship Between Medical Malpractice and Quality of Care," 1975 Duke L. J. 1197, 1216 (1975).

[53] Neisser, supra n.7, at 957 n.141.

[54] While a state malpractice remedy is theoretically available to inmates, they face various obstacles in bringing such cases. See Comment, "Inadequate Medical Treatment of State Prisoners," supra n.10,

to have little effect on the behavior of medical practitioners.[55]

Finally, because the doctor-patient relationship in a correctional facility is imposed by the state, the dissatisfied patient is not free to select a different provider. This absence of freedom of choice removes the "competitive quality controls" of the market place that normally influence the behavior of physicians.[56]

Thus, in a correctional institution, the protections afforded unconfined

(footnote cont'd)

at 116-119.

55 Grad, supra n.52, at 1067 n.39; Wiley, "The Impact of Judicial Decisions on Professional Conduct: An Empirical Study," 55 So. Cal. L. Rev. 345, 384-5 (1981).

56 Neisser, supra n.7, at 938; see also Brecher & Della Penna, supra n.6, at 69.

patients are replaced by institutional imperatives. The unavailability of professional standard-setting mechanisms guarantees the continuing presence of some health practitioners least able or willing to exercise the professional judgment that the court of appeals erroneously assumed is present in all cases.

II. BECAUSE PRISON MEDICAL CARE LITIGATION HAS RESULTED IN ENORMOUS PUBLIC HEALTH BENEFITS AND SINCE EXISTING LAW FULLY PROTECTS PROFESSIONAL MEDICAL JUDGMENT, THE COURT SHOULD NOT ADOPT A "COLOR OF LAW" STANDARD THAT UNDULY OBSTRUCTS THE LITIGATION OF SUBSTANTIAL EIGHTH AMENDMENT CLAIMS.

APHA agrees that the genuine exercise of professional discretion is not, and should not be, actionable under § 1983. Because such independence in prison medical care is sometimes illusory and usually precarious, however, the Court should not adopt the Fourth Circuit's "color of law" rule that assumes its existence in all

cases.

Fifteen years of prison health care litigation has fostered substantial benefit to a traditionally underserved population and to the general public. This has been accomplished without infringing upon the protected sphere of professional autonomy because the substantive Eighth Amendment standard for such claims insulates professional medical judgment from federal court review. See Estelle v. Gamble, supra.

The success of the litigation has depended in large part on the well-established view that prison medical staff act under color of state law. A "color of law" rule that broadly excludes such staff from the scope of § 1983 would seriously impair the enforcement of prisoners' constitutional right to minimally decent medical care.

A. Federal Court Prison Medical Care Litigation Has Substantially Improved the Public Health, and its Continued Availability Is Essential.

In the view of the APHA, the federal court remedy under Estelle v. Gamble has fostered major improvements in the medical care of prisoners in the United States.[57] The prison cases are replete with accounts

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[57] Informed observers agree. A special master in a number of complex prison class actions has written: "No serious student of American correctional history can deny that litigation has provided the impetus for reform of medical practice in prisons in jails. . . ." Nathan, supra n.16, at 3. A noted scholar of correctional matters observed: "During the 1970's medical care for American prisoners vastly improved. In no small part this trend may be attributed to the Supreme Court's decision in Estelle v. Gamble. . . ." Jacobs, New Perspectives on Prisons and Imprisonment at 29 (1983). Accord, Wishart & Dubler, supra n.6, at 5; Resnik & Shaw, "Prisoners of Their Sex: Health Problems of Incarcerated Women," in Robbins (ed.) II Prisoners' Rights Sourcebook 319, 320-21 (1980); Harris & Spiller, "After Decision: Implementation of Judicial Decrees in Correctional Settings" at 20-21 (American Bar Association, November 1976).

of inadequate and inhumane health care systems that have been elevated to constitutional acceptability through federal court litigation.[58] More generally, the prospect of litigation has encouraged corrections officials to improve medical services without waiting to be sued and has contributed to the development of professional standards governing prison health care.[59]

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58 Compare Battle v. Anderson, 376 F.Supp. 402, 415-16 (E.D.Okla. 1974), with Battle v. Anderson, 788 F.2d 1421, 1426-27 (10th Cir. 1986); Jones v. Wittenberg, 330 F.Supp. 707, 718 (N.D.Ohio 1971), aff'd sub nom. Jones v. Metzer, 456 F.2d 854 (6th Cir. 1972), with Jones v. Wittenberg, 509 F.Supp. 653, 684-87 (N.D.Ohio 1980); Lightfoot v. Walker, 486 F.Supp. 504 (S.D.Ill. 1980), with Lightfoot v. Walker, 619 F.Supp. 1481, 1489 (S.D.Ill. 1985), aff'd, 826 F.2d 516 (7th Cir. 1987); Finney v. Arkansas Board of Correction, 505 F.2d 194, 202-04 (8th Cir. 1974), subsequent order affirmed sub nom. Hutto v. Finney, 437 U.S. 678 (1978), with Finney v. Mabry, 546 F.Supp. 628, 631 (E.D.Ark. 1982).

59 Jacobs, supra n.57, at 29, 50-51, 57, 59; see also APHA Standards, supra n.6,

Although prison health care has substantially improved, the task is by no means complete. The same patterns of neglect and disorganization first exposed in the litigation of the early- and mid-1970's remain in many jails and prisons.[60] Some institutions -- particularly local jails -- remain untouched either by litigation or by the more general movement toward improved health care. Moreover, the struggle for adequate prison health care is never permanently won; growing inmate populations and competing demands

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(footnote cont'd)

n.6, vi-vii et passim (citing case law in support of standards).

60 See French v. Owens, 777 F.2d 1250, 1251, 1254-55 (7th Cir. 1985), cert. denied, ___U.S.___, 107 S.Ct. 77 (1986) (proof updated in 1984); Ruiz v. McCotter, 661 F.Supp. 112, 147 (S.D.Tex. 1986); Palmigiano v. Garrahy, 639 F.Supp. 244, 252-54 (D.R.I. 1986); Dean v. Coughlin, 623 F.Supp. at 395 (proof from 1984-85).

on governmental resources jeopardize the gains of the last decade.[61]

B. Existing Law Has Protected Prisoners' Rights to Minimally Decent Health Care Without Invading the Professional Discretion of Medical Practitioners.

In Estelle v. Gamble, 429 U.S. at 104, the Court held that "deliberate indifference to serious medical needs of prisoners" violates the Eighth Amendment's prohibition of cruel and unusual punishment. The Court distinguished such conduct from merely inadvertent or negligent diagnosis or treatment by a physician: "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." Id. at 106.[62]

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61 See, e.g., Duran v. Anaya, 642 F.Supp. 510 (D.N.M. 1986) (preliminary injunction granted against cuts in medical and mental health care staffing that would threaten compliance with previously entered consent decree).

62 The court below did not determine

The Court found that the Estelle plaintiff's complaint was "a classic example of a matter for medical judgment" and as such was not cruel and unusual punishment.[63]

By applying this distinction, in both individual cases and injunctive class

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(footnote cont'd)

whether the allegations of petitioner's complaint state a claim under Estelle.

63 Id. at 107. The Court later adopted a similar approach to the due process right of mental patients to be free from excessive physical restraint, holding that decisions should be made by mental health professionals but that the courts should "make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." Youngberg v. Romeo, 457 U.S. 307, 321 (1982), quoting Romeo v. Youngberg, 644 F.2d 147, 178 (3d Cir. 1980) (en banc) (Seitz, C.J., concurring). Cf. Vitek v. Jones, 445 U.S. 480, 495 (1980) (that the transfer of a prisoner to a mental institution involves medical judgment does not preclude due process protections).

actions, the federal courts have avoided invading or second-guessing the legitimate exercise of professional judgment. Mere disagreements with prison doctors or criticisms of their judgment do not state constitutional claims.[64] Rather, the federal prison health care cases focus primarily on outright denials of care, the absence of medical judgment,[65] factors

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[64] See, e.g., Wright v. Collins, 766 F.2d 841, 849 (4th Cir. 1985); Randall v. Wyrick, 642 F.2d 304, 308 (8th Cir. 1981) and cases cited; Ferranti v. Moran, 618 F.2d 888, 891 (1st Cir. 1980); McCracken v. Jones, 562 F.2d 22, 24 (10th Cir. 1977), cert. denied, 435 U.S. 917 (1978); Limbert v. Umar, 585 F.Supp. 1413 (E.D.Pa. 1984); Burns v. Head Jailor, 576 F.Supp. 618, 620 (N.D.Ill. 1984).

[65] See, e.g., H.C. by Hewett v. Jarrard, 786 F.2d 1080, 1086-87 (11th Cir. 1986) (inmate placed in isolation and kept from having his injuries evaluated); Hurst v. Phelps, 579 F.2d 940 (5th Cir. 1978) (refusal to take prisoner to doctor's appointments); Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754, 762 (3d Cir. 1979) (lack of access to psychiatric diagnosis and treatment); see also cases cited in Estelle v. Gamble, 429 U.S. at 105, n.11.

interfering with the exercise of such judgment,[66] or failures to carry out medical decisions once made.[67]

The actual decisions of prison medical personnel are at issue under Estelle only when "[deliberate] indifference is manifested by prison doctors in their response to the prisoner's needs. . . .," 429 U.S. at 104 (footnote omitted) -- that

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[66] See, e.g., Matzker v. Herr, 748 F.2d 1142, 1147-48 (7th Cir. 1984) (three-month failure to treat eye and dental injuries because jail "lacked the facilities"); Todaro v. Ward, 431 F.Supp. at 1144-45 (sick call procedure conducted under conditions that precluded an adequate examination by nursing professionals).

[67] See, e.g., Gill v. Mooney, 824 F.2d 192, 195-96 (2d Cir. 1987) (inmate forced to carry heavy load and denied rehabilitative exercise, both contrary to medical orders); Cummings v. Dunn, 630 F.2d 649 (8th Cir. 1980) (denial of medication); see also cases cited in Estelle v. Gamble, 429 U.S. at 105 n.12.

is, when they are not actually medical in nature,[68] or are so extreme or abusive as to be completely outside the range of professional medical judgment.[69]

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[68] A prisoner's allegation that he was denied surgery for a painful condition by a doctor for budgetary rather than medical reasons raised an Eighth Amendment claim. Jones v. Johnson, 781 F.2d 769 (9th Cir. 1986); accord, Jorden v. Farrier, 738 F.2d 1347 (8th Cir. 1986) (denial of previously prescribed medication by prison doctor would be actionable if administrative rather than medical in nature); see Neisser, supra n.7, at 959-60.

[69] Thus, in Williams v. Vincent, 508 F.2d 541, 544-45 (2d Cir. 1974), cited with approval in Estelle, 429 U.S. at 104 n. 10, an Eighth Amendment claim was stated by the allegation that a prison doctor threw away the plaintiff's severed ear rather than trying to reattach it, simply because it was easier. See other cases cited in Estelle, id.; see also Rogers v. Evans, 792 F.2d 1052, 1059-62 (11th Cir. 1986) (evidence that psychiatrist avoided prisoner after complaints were made about treatment and that diagnosis and treatment were completely outside the range of professional judgment created a triable Eighth Amendment issue); Wells v. Franzen, 777 F.2d 1258, 1264-65 (7th Cir. 1985) (deprivation of shackled inmate of exercise, clothing and showers, and requirement that he eat with his fingers next to his two-day-old urine); Knecht v. Gillman,

Similarly, in injunctive challenges to prison medical systems, the federal courts have not only protected the sphere of judgment surrounding medical practitioners' treatment and diagnostic decisions but have often enhanced it. At issue in a typical injunctive case are such matters as staffing, physical facilities, transportation, and sick call and follow-up procedures. See, e.g., Wellman v. Faulkner, 715 F.2d 269, 272-74 (7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984); Ramos v. Lamm, 639 F.2d 559, 575-76 (10th Cir.), cert. denied, 450 U.S. 1041 (1980); Inmates of Allegheny County Jail v. Pierce, 612 F.2d at 761-63. When

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(footnote cont'd)

488 F.2d 1136 (8th Cir. 1973) (use of drug that induced vomiting as "aversive therapy" for rules violations). Cf. Youngberg v. Romeo, 457 U.S. at 321 (discussion at n.63, supra).

a court orders relief in these areas, it is assuring that the raw materials from which responsible professional judgment is formed are available to practitioners.

C. The Courts Must Be Able to Enjoin Health Care Staff Directly in Order to Fashion Effective Relief for Violations of the Constitutional Standard.

In injunctive § 1983 cases, it may sometimes be sufficient to enjoin prison wardens or other officials who interfere with medical decisions or who fail to provide adequate medical staff or other resources. In other situations, part or all of the constitutional violation lies in the acts or omissions of the medical staff themselves. Where health care practitioners, through disorganization, bad intent, or lack of interest are themselves not exercising professional judgment, it is clearly a practical necessity that they be parties defendant and be subject to the

terms of injunctions.

For example, in one systemic case, the court found constitutional violations in inadequate sick call procedures, lack of access to medical practitioners by infirmary patients, and failure to follow up abnormal test results. The court ordered that practitioners keep records of their encounters with sick call patients,[70] that nurses and doctors conduct infirmary rounds, and that the physicians who order tests review the results for abnormalities. Todaro v.

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[70] The court found a constitutional violation in nurses' failure to make adequate records of medical complaints, Todaro v. Ward, 431 F.Supp. at 1145-6, and several other courts have ruled similarly. Hoptowit v. Ray, 682 F.2d 1237, 1252-54 (9th Cir. 1982); Burks v. Teasdale, 492 F.Supp. 650, 660-65 (W.D.Mo. 1980); Lightfoot v. Walker, 486 F.Supp. at 517, 527. Adequate medical records are an indispensable element of correctional health care. Neisser, supra n.7, at 970; APHA Standards, supra n.1, Part 11, at 99.

Ward, 431 F.Supp. at 1151-53, 1160.[71] In another case, involving unconstitutional delays in access to dental care and a failure to provide treatment that was ordered, Dean v. Coughlin, 623 F.Supp. 392 (S.D.N.Y. 1985),[72] the court imposed general deadlines for the delivery of services, subject in each case to the individualized professional judgment of the treating dentist.[73]

In entering such orders, courts may properly require that professional discre-

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[71] Excerpts from the injunction in Todaro are set forth in Wishart & Dubler, supra n.6, at 169-73.

[72] The court found, inter alia, that the staff dentist and dental hygienist had ignored over three hundred written requests for dental appointments because they considered them "worthless." Id. at 395.

[73] 633 F. Supp. 308, 310-15 (S.D.N.Y), injunction vacated on other grounds but pertinent portion approved, 804 F.2d 207, 215-6 n.2 (2d Cir. 1986).

tion be exercised, on an informed basis,[74] without dictating the outcome of medical judgment. For example, courts have required the treating physician to specify the time for a test or examination or within which a specialist consultation or hospital admission must occur. In turn, once the doctor has determined the appropriate time limits, the court will direct that the order be honored by other medical and correctional staff.[75] In such cases, it serves, rather than detracts from, the independence of medical professionals when the courts

> ... ensure that decisions concerning the nature and timing of medical care are made by medical personnel, using equipment

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[74] See Neisser, supra n.7, at 956-69.

[75] Neisser, supra n.7, at 971-2; Winner, supra n.37, at 77-79. See also Todaro v. Ward, 431 F. Supp. at 1152; Miller v. Carson, 401 F. Supp. 835, 878 (M.D. Fla. 1975).

> designed for medical use, in locations conducive to medical functions, and for reasons that are purely medical.[76]

D. Orders Requiring Custodial and Supervisory Personnel to Guarantee the Performance of Health Care Providers Would Decrease Their Professional Independence.

A touchstone of APHA's approach to prison health care is the professional independence of the medical unit within the correction setting. Medical staff should be hired, supervised, and dismissed by medical superiors and accountable to them rather than correctional officials. Maintaining separate medical and correctional lines of authority helps to safeguard professional autonomy.

Yet, the necessary result of affirmance of the decision below would be the issuance of regulatory injunctions

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76 Neisser, supra n.7, at 956-7.

regarding the professional performance of health care staff against lay wardens and department heads, who will be the only defendants left. Such a result is both theoretically unsound and practically unworkable. Non-health-care supervisors cannot be expected to determine if accurate medical records are being kept, whether meaningful examinations or rounds are conducted, or if test results are abnormal. They will be unable to tell whether compliance with orders concerning such matters is genuine or a sham.

Worse, such an outcome will reimpose the "disorganized lines of therapeutic responsibility"[77] that guarantee correctional interference with medical care delivery and which advocates of prison

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77 See Newman v. Alabama, 503 F.2d 1320, 1331 (5th Cir. 1974), cert. denied, 421 U.S. 948 (1975).

health care have attempted for years to overcome.[78] This Court ought not eliminate from § 1983 cases those defendants who, by training and responsibility, are in the best position to effectuate injunctive relief designed to upgrade health care delivery to constitutional minima.

III. HEALTH CARE PRACTITIONERS SHOULD BE CONSIDERED TO BE ACTING "UNDER COLOR OF STATE LAW" WHEN THEY TREAT INMATES MORE THAN OCCASIONALLY IN A SETTING THAT IS DEMONSTRABLY CORRECTIONAL OR UNDER CIRCUMSTANCES THAT SUBSTANTIALLY DISTINGUISH THE PRISONER-PATIENT FROM OTHER PATIENTS SERVED.

In this case, the definition of "color of law" must acknowledge the realities of correctional medical practice. As shown supra, the Fourth Circuit

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78 "If medical care decisions constitutionally may be made only by medical personnel, correctional supervision of such personnel necessarily seems unacceptable." Neisser, supra n.7, at 961.

erred in assuming that prison health staff, like the public defenders in Polk County v. Dodson, enjoy such "independence from administrative direction," 815 F.2d at 995, that their decisions are uninfluenced by the institutional setting, and that they are wholly divorced from custodial and supervisory functions. A definition of color of law should not be based on these false premises.

Amicus proposes that prison medical staff should be deemed to act under color of state law when they treat inmates more than occasionally in a setting that is demonstrably correctional or under circumstances that substantially distinguish prisoners from other patients served. This test attributes the activities of prison health staff to the state when circumstances caution that their actions, clearly "clothed with the authority of

state law,"[79] are also most likely to be pervasively affected by it. The standard is a functional one, avoiding talismanic reliance on the place of treatment or the practitioner's employment status and focussing instead on his or her degree of involvement with the correctional system and with prisoner-patients as a group. The test recognizes, however, that not all health professionals who treat inmates are influenced to the same degree[80] and that a reasonable line must be drawn because of the variety of contexts in which correctional health care is delivered.

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79 Monroe v. Pape, 365 U.S. 167, 184 (1961), quoting United States v. Classic, 313 U.S. 325, 326 (1941).

80 Amicus does not suggest that practitioners who fit within the proposed standard regularly violate the Constitution but rather that there is sufficient state involvement in their conduct to subject them to "deliberate indifference" scrutiny under § 1983.

Under this test, the full-time public employees of a state or local government performing medical services within a prison or jail should be considered to act under color of state law when they treat patients. These doctors, nurses, physician's assistants and others are the paradigmatic group on whose work the prison milieu most strongly impinges. The standard will in some cases, but not all, also include as state actors consulting, part-time, and contractual employees.

A. Consulting, Part-time, and Contractual Health Professionals Are Subject to the Same Correctional Influences on Professional Judgment As Regular Institutional Staff.

Prisons and jails cannot offer all the personnel and facilities needed for inmates' medical care. As a result, there is almost universal reliance on outside consultants and services, usually on a

part-time[81] or contractual basis.[82] Correctional imperatives affect the behavior of these employees.

The medical consultation process in a prison is influenced by the same factors that affect prison and jail health delivery systems generally. Consultations involve issues of security, transportation, administration, and communication between the referring and the consulting physicians. Simply locating a consultant willing to see prisoners can be a major problem, and once one is found the epidemiological characteristics of prisons and jails and the difficulty or impossibility of providing sophisticated medication regimens, diets, prostheses, or diagnostic procedures on cell blocks or even in prison infirmaries all affect the exercise of medical judgment by the consultant,[83] as illustrated by the advice to prison medical consultants described supra at 16-17.

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81 Since small jails rely almost exclusively on fee-for-service health staff, Steinwald, et al., Medical Care in U.S. Jails 22 (American Medical Association 1973), excluding them from the definition of "color of law" would create a double standard based on institution size and arbitrarily deprive some inmates of a remedy available to those in larger systems.

82 A recent survey showed that only four states had no contractual prison medical services; another four had contracted out all their health services. In some cases, contractual services are rendered at outside hospitals or doctors' private offices; in other cases, including that of the North Carolina physician in this case, the contractual practitioner renders care in the prison itself. "Prison Health Care," 11 Corrections Compendium 7-14 (July 1986).

83 For example, it may be impossible to perform many procedures or arrive at certain diagnoses precisely because the patient is in a correctional institution. An example of this is twenty-four hour collection of urine for analysis -- easy in the patient's home, nearly impossible in the lockup. Lessenger & Bader, supra n.19, at 97.

Similar forces affect the behavior of part-time and contractual[84] employees. It is their function within the institution, not their employee status, that determines whether their professional independence is sufficiently assured to consider them independent of state action.

Such influences will be stronger as the frequency of contact with the institution increases. Thus, when practitioners treat inmate patients regularly or frequently (i.e., "more than occasionally"), they are more likely to be affected by

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84 The Fourth Circuit's decision in Calvert v. Sharp, 748 F.2d 861, 863 (4th Cir. 1984), cert. denied, 471 U.S. 1132 (1985), upon which the en banc court relied in the instant case, found that a doctor's status as an employee of a company providing prison medical services under contract was determinative in defeating state action. For the reasons set forth in this brief, exclusive reliance on this factor is misplaced. See Ort v. Pinchback, 786 F.2d 1105, 1107 (11th Cir. 1986).

non-medical considerations than is a practitioner with casual or episodic contact. If these patient encounters occur within a prison or in special inmate facilities, such as secure wards (i.e., "under circumstances that are demonstrably correctional"),[85] one can expect the institutional influences on the behavior of health workers to be sufficiently pervasive to characterize them as acting under color of state law.

Similarly, if practitioners treat prisoner-patients "more than occasionally" under circumstances that are very different from their ordinary civilian physician-patient relationships (i.e., prisoner-patients are "substantially dis-

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85 Lessenger & Bader, supra n.19, at 99, suggest that hospitals who do not want shackled prisoners and uniformed guards in their departments arrange for the patient to be seen in a separate secure room.

tinguished" from other patients), care should be deemed to occur under color of state law. Examples include private dentists who regularly treat prisoners in their own offices but limit their services to extractions and specialists, paid by the visit, who provide cursory examinations of or treatment for inmates seen in groups.

Adoption of this test will assure that the activities of health professionals -- full-time, part-time, consulting or contractual -- are subject to federal court jurisdiction when there is danger that their performance will be inadequate, not due to any mistake, inadvertence, or negligence, but because the state-imposed correctional setting has changed the way they practice.

B. The Proposed Standard Is Easily Applied and Will Avoid Biasing the States' Decisions As to the Privatization of Prison Health Services.

The proposed standard, although fact-based, is not difficult in application, and the employees' status as state actors can be resolved in most cases on summary judgment without a hearing. The test is also consistent with the "necessarily fact-bound inquiry" prescribed in this Court's prior color of law cases. "Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance." Lugar v. Edmondson Oil Co., 457 U.S. 922, 939 (1982), quoting Burton v. Wilmington Parking Authority, 365 U.S. 715, 722 (1961)[86] The lower court's wide-ranging application

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[86] Accord, Flagg Brothers, Inc. v. Brooks, 436 U.S. 149, 164 (1978).

of Polk County v. Dodson, while perhaps offering the surface appeal of greater simplicity, ignores the warning that "differences in circumstances beget differences in law," Jackson v. Metropolitan Edison Co., 419 U.S. 345, 358 (1974), and that professional discretion exercised by a public defender under the scrutiny of a court is different from the actions of a prison doctor serving at the pleasure of the warden.

In adopting the proposed standard, the Court will avoid biasing governmental decisions as to the best means of supplying prison medical care. There is already some evidence that governmental units have embraced "privatization" of prison services in the hope of avoiding or minimizing legal liability or dispersing accountability.[87]

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[87] NKC Management, Evaluation of the State

The relative merits of contractual and in-house medical services for prisons and jails depend on numerous factors, including the type of service, the geographical area, and the kind of popula-

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(footnote cont'd)

of Maryland's Medical Services Program for Inmates (November 1986) at 19-20; Note, "Inmates' Rights and the Privatization of Prisons," 86 Col.L.Rev. 1475, 1499-1500 nn. 171-72 and materials cited (1986); Robbins, "Privatization of Corrections: Defining the Issues," in Robbins (ed.), Prisoners and the Law 22-3 - 22-5 (1987). Dispersion of accountability can lead to the belief that one's actions are beyond the law. An employee who reviewed disciplinary cases at a privately run Immigration and Naturalization Service facility in Houston recently boasted to a reporter: "I'm the Supreme Court." Robbins, id., citing N.Y. Times (Feb. 19, 1985) at A15. Cf. Evans v. Newton, 382 U.S. 296 (1966) (public park transferred to private management to avoid reach of civil rights laws); Classen, "Hospital Liability for Independent Contractors: Where Do We Go from Here?" 40 Ark. L. Rev. 469, 471 (1987) (courts view independent contractor clauses as "thinly veiled attempts by hospitals to shirk their responsibility to the patient") (footnote omitted).

tion to be served. The choice should be based solely on considerations of providing adequate services, and the Court should not adopt a legal rule that would distort it.

CONCLUSION

The judgment of the United States Court of Appeals for the Fourth Circuit should be reversed.

Respectfully submitted,

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